PROCEDURAL/SURGICAL PROCTOR/PRECEPTOR EVALUATION FORM

Practitioner's Name: ____________________________________

Clinical Service: _______________________________________

Procedure/Surgery Performed at: (circle): BGMC DMH MFS OCH KLEIN ROAD ASC SOUTHTOWNS ASC

Date of Procedure/Surgery: ____/____/____

Procedure/Surgery: ________________________________

Medical Record Number: ___________________________

Start Time: ___________ Duration of Surgery/Procedure: ________hours_______minutes

EVALUATION:

Please evaluate each item with a letter choice. A comment is required if you indicate I, B or N:
I = Improvement needed  B = Borderline (additional training needed)  N = Not competent
C = Competent (meets standards)  E = Excels (high level performance)  NA = Not Applicable

Medical Expertise:

___Followed appropriate selection criteria for patient and procedure: ______________________________

___Performed a comprehensive pre-operative evaluation:

  appropriate for the specific procedure and patient: ______________________________

___Adequately prepared patient and procedural/surgical site: ______________________________

Technical Expertise:

___Demonstrated familiarity with instrumentation/dexterity: ______________________________

___Demonstrated appropriate procedural/surgical skills: ______________________________

___Tissue manipulation: ______________________________

___Tissue dissection/transsection: ______________________________

___Suturing: ______________________________

Judgement:

___Demonstrated appropriate clinical judgement: ______________________________

___Completed procedure in a safe, expeditious manner: ______________________________

___Completed procedure without complications: ______________________________

___Detaled a comprehensive post-operative plan; appropriate to patient and procedure: ______________________________
CONCLUSION: (Please choose one, use reverse side for additional comments)

Practitioner has demonstrated he/she is technically competent to perform this procedure independently (Obtained all C/E for above items) include comments:

Practitioner shows improvement yet more training is needed (Obtained I in above review) include comments/recommendations:

Practitioner has not yet demonstrated he/she is competent to perform this procedure (Obtained B/N in above review) include comments/recommendations:

Practitioner's Name: ________________________________

Signature: ________________________________ Date: ____/____/____

****A separate form is to be completed after each case.

Send completed form to: KH Medical Staff Office, 1028 Main Street – 3rd Floor, Buffalo, NY 14202; Attn: Supervisor/Medical Staff Office